Home Health Certification and Plan of Care

Order ID: 1150/19533

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
36165256	06/08/2026	From: 06/08/2026 To: 08/06/2026	26675	217058

6. Patient's Name and Address
Edith Lewis-Brooks
3912 Millner Rd,
NOTTINGHAM, MD 21236-
240-460-1390

7. Provider's Name, Address and Telephone Number
HomeCentris Healthcare LLC
10 Crossroads Drive, Suite 102
Owings Mills, MD 21117-8284
410-321-8448
1487113239

8. DOB 03/17/1957 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I27.20	Pulmonary hypertension unspecified	06/08/26

13. ICD	Other Pertinent Diagnoses	Date
M32.9	Systemic lupus erythematosus unspecified	06/08/26
J84.9	Interstitial pulmonary disease unspecified	06/08/26
I11.0	Hypertensive heart disease with heart failure	06/08/26
I50.31	Acute diastolic (congestive) heart failure	06/08/26
I07.1	Rheumatic tricuspid insufficiency	06/08/26
J43.9	Emphysema unspecified	06/08/26
Z79.52	Long term (current) use of systemic steroids	06/08/26

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

Sulfamethoxazole And Trimethoprim - Sulfamethoxazole: Trimethoprim 400-80 mg / 1 Tablet by mouth once a day Commonly known as: BACTRIM SS
Hydroxychloroquine Sulfate - Hydroxychloroquine Sulfate 200 mg / 1 Tablet by mouth once a day Commonly known as: PLAQUENIL
Famotidine - Famotidine 20 mg / 1 Tablet by mouth twice a day Commonly known as: PEPCID
Thiamine - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 100 mg / 1 Tablet by mouth once a day Commonly known as: VITAMIN B-1
Prednisone - Prednisone 20 mg/tablet / Take 2 tablets by mouth once a day
Azathioprine - Azathioprine Sodium 50 mg / 1 Tablet by mouth once a day Commonly known as: IMURAN
Furosemide - Furosemide 20 mg / 1 Tablet by mouth once a day Commonly known as: LASIX
Lisinopril - Lisinopril 20 mg / 1 Tablet by mouth once a day Commonly known as: ZESTRIL
Oxygen - Oxygen 3 L nasal cannula continuous SOB

14. DME and Supplies:
bath bench, oxygen supplies, cane

15. Safety Measures:
O2 precautions, medication safety, fall precautions, ambulates with device, standard precautions, bathroom safety

16. Nutrition:
renal diet

17. Allergies:
mycophenolate mofetel

18.A. Functional Limitations
Dyspnea With Minimal Exertion, Ambulation

18.B. Activities Permitted
Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

22.B.Discharge Plans
patient will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Pulmonary hypertension unspecified, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device.

Clinical Condition Requiring Homecare: The patient is a 69-year-old female referred to home health services following hospitalization for worsening shortness of breath and fluid retention. Her past medical history is significant for pulmonary hypertension, systemic lupus erythematosus, interstitial lung disease, hypertensive heart disease with heart failure, acute diastolic heart failure, and chronic respiratory insufficiency requiring supplemental oxygen. Prior to hospitalization, the patient resided with her husband in Western Maryland, was independent with ambulation without an assistive device, independent with transfers, activities of daily living (ADLs), instrumental activities of daily living (IADLs), and driving, and did not require supplemental oxygen. Following hospitalization and stabilization, the patient was discharged to her daughter's home, where she currently resides with her daughter and family. The patient reported that her husband is currently hospitalized in the intensive care unit following a cerebrovascular accident, and she plans to eventually transition to a senior living apartment. The patient initially presented to her primary care provider with worsening shortness of breath and was subsequently referred to urgent care after oxygen saturation levels were noted to be in the 60% range. She was treated with noninvasive ventilation and diuretic therapy, resulting in clinical stabilization and improvement in symptoms. Upon home health assessment, the patient was alert and oriented to person, place, time, and situation. She reported feeling improved since discharge but continues to require continuous oxygen therapy at 3 L/min via nasal cannula. The patient has a documented history of medication noncompliance and reported previously discontinuing Lasix due to increased urinary frequency. Education was provided regarding the importance of medication adherence, disease management, and the role of diuretic therapy in controlling fluid retention and heart failure symptoms. Medication reconciliation was completed, and the patient was instructed to take Lasix 20 mg by mouth once daily in the morning as prescribed. The patient verbalized understanding of the medication regimen and associated teaching. During the skilled nursing assessment, the patient's blood pressure was noted to be significantly low at 79/45 mmHg. She was encouraged to increase fluid intake, and upon reassessment several minutes later, her blood pressure improved slightly to 86/50 mmHg. The primary care provider was notified regarding the hypotensive readings, and further recommendations were requested. The patient denied acute distress during the visit. Assessment also revealed a draining wound located on the posterior aspect of the right lower leg. Current wound care orders include wet-to-dry dressing changes every other day. Due to continued drainage, a recommendation was communicated to the primary care provider to consider changing the dressing regimen to calcium alginate to better manage exudate and promote wound healing. At the time of documentation, a response from the provider was pending. Review of the discharge summary also identified an order to repeat a Chem 7 laboratory panel within one to two weeks following discharge for ongoing monitoring. Functional assessment revealed significant decline from the patient's prior level of function. The patient ambulates slowly using a cane or by holding onto furniture and requires assistance for safe management of oxygen tubing. Physical therapy evaluation identified lower extremity weakness, impaired balance, decreased endurance, impaired gait sequencing, reduced transfer ability, decreased bed mobility, and difficulty with stair negotiation. The patient fatigues easily and experiences dyspnea with activity, requiring frequent rest periods. Balance testing using the Tinetti Assessment Tool yielded a score of 16/28, indicating an increased risk for falls. The patient currently requires contact guard assistance for transfers, minimal assistance to contact guard assistance for ambulation without an assistive device, and minimal assistance for negotiating single steps. Skilled physical therapy is medically necessary to address lower extremity strengthening, gait training, balance retraining, endurance improvement, transfer training, stair negotiation, oxygen line management, safety awareness, and fall prevention to maximize functional independence and reduce the risk of hospitalization. Occupational therapy evaluation further identified deficits in standing balance, standing tolerance, bilateral upper extremity strength, and overall activity tolerance. These impairments have resulted in decreased independence with self-care activities, functional transfers, and household mobility. Prior to hospitalization, the patient was independent with all self-care tasks and functional mobility. Skilled occupational therapy services are recommended to improve upper extremity strength, activity tolerance, safety with ADLs, functional transfer performance, energy conservation techniques, and overall independence to facilitate a return toward her prior level of function. Comprehensive education was provided regarding medication compliance, oxygen safety and oxygen use precautions, fall prevention strategies, wound care management, and recognition of symptoms requiring medical attention. The patient verbalized understanding of

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/08/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Naeha Quasba
7141 Security Blvd
Baltimore, MD 21244
PHONE: 410-230-7827 FAX: 1-410-230-7827 NPI: 1609119049

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
F2F date : 06/04/2026

27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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all instructions provided. The plan of care includes continued skilled nursing for cardiopulmonary assessment, blood pressure monitoring, medication management, wound assessment and treatment, laboratory follow-up, and reinforcement of disease management education. Skilled physical and occupational therapy services will continue to address mobility, strength, balance, endurance, safety, and functional independence with the goal of improving overall health status and enabling the patient to safely remain in the home environment.
 Date of Order 06/08/2026 Orders Physician Face-to-Face Date: 06/04/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Pulmonary hypertension unspecified Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Quasba, Naeha

SN Careplans

SN WK1: 1 (06/08/26-06/13/26) ,WK2: 1 (06/14/26-06/20/26) ,WK3: 1 (06/21/26-06/27/26) ,WK4: 1 (06/28/26-07/04/26) ,WK5: 1 (07/05/26-07/11/26) ,WK7: 1 (07/19/26-07/25/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.
Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.
Provide education content at patient's level of health literacy.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.
Assess: Musculoskeletal status.
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, muscle weakness, balance deficit, open sores/lesions, #1 - Open Wound - Posterior Right Ankle/Foot - WOUND CARE DONE

PROCEDURES: physician-ordered wound care: #1 - Open Wound - Posterior Right Ankle/Foot - WOUND CARE DONE: Clean with normal saline, apply calcium alginate and cover with bordered foam dressing. Change every other day or PRN., cough/deep breathing exercises, incentive spirometer

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

SN Goals

PATIENT-STATED GOAL: To get well/better.

GOALS
patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

06/08/2026

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PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Medication management : Review medication with pt and caregiver, home exercise program: Laq, heelraises, hamstring curls, hip abduction, hip extension, hip flexion. Seated tes and standing as tolerated, equipment training: Train on safe mgmt of oxygen line, dynamic standing balance exercises: To work on wt shifting outside bos demos good reaction time, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

PATIENT-STATED GOAL: Pt improve my strength walk and get up and down the steps easier amd move into a senior citizen apt

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

OT Careplans

OT WK1: 1 (06/08/26-06/13/26) ,WK3: 1 (06/21/26-06/27/26) ,WK5: 1 (07/05/26-07/11/26) ,WK7: 1 (07/19/26-07/25/26) ,WK9: 1 (08/02/26-08/06/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing

PROCEDURES: Medication Review : Medication reviewed with patient with all medications in the home, cough/deep breathing exercises, incentive spirometer, home exercise program: Bilateral UE strengthening of deltoid, biceps, triceps muscles, therapeutic exercises: Skilled OT, equipment training, work simplification/energy conservation, transfers training: Skilled OT, assist with bathing: Skilled OT, assist with transferring: Skilled OT

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Walk better

GOALS
patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

HHA Careplans

HHA WK2: 1 (06/14/26-06/20/26) ,WK3: 1 (06/21/26-06/27/26) ,WK4: 1 (06/28/26-07/04/26) ,WK5: 1 (07/05/26-07/11/26) ,WK6: 1 (07/12/26-07/18/26) ,WK7: 1 (07/19/26-07/25/26) ,WK8: 1 (07/26/26-08/01/26)

HHA Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
06/08/2026